Political Motivations for Variance in Eligibility and State Spending on Medicaid

A Senior Honors Thesis

Presented in Partial Fulfillment of the Requirements for Graduation
with Research Distinction in Political Science in the Undergraduate Colleges
of The Ohio State University

by

Ronald J. Lieberman

The Ohio State University

April 2013

Project Advisor: Professor Philipp Rehm, Department of Political Science

Abstract

Medicaid is one of the largest portions of US social welfare, costing the states' and federal government $389 billion in 2010 and offering coverage to 20% of the entire US population. Yet, it remains a poorly understood institution, despite the wealth of social welfare research done in the US. Previous work has focused primarily on the influence of per capita incomes and other economic indicators on the strength of the Medicaid programs, neglecting many alternative perspectives. Within in this essay, I propose a new way of looking at Medicaid, disregarding the role of money and instead focusing on the role of votes, elections, and ideology. Politicians control Medicaid and one of politicians' most pressing concerns is reelection. If we instead view Medicaid as a borderline populist tool for winning votes, we can add to our understanding. By examining how much competition for election politicians face and how liberal or conservative they are, this essay attempts to offer new explanations for Medicaid outcomes. I found that this perspective gives us a new general predictor of what the strength of a state's Medicaid program will be.

I. Introduction

In the introduction to his book *The Divided Welfare State*, Jacob S. Hacker writes that social welfare programs have been, "at the heart of the struggle over US social policy from the dawn of the modern American state" (Hacker 2002, xi). What programs to support, how to fund these programs, how to operate them, and who to include have all become divisive issues in American politics. Given such contested debate over social welfare policy, the final outcomes, the programs themselves, are often far less clear and more complex than originally intended in order to satisfy differing political ideologies; the programs are left open to interpretation and manipulation for those who must implement them.

Arguably in no other case is this more true than the Medicaid program, a federally supported, but state designed and operated welfare medicine institution, with the original goal of providing health services to America's most impoverished. The programs vary greatly in their strength and scope across the 50 states and Washington DC, evidence of differing interpretations by the respective legislatures. The focus of this essay then, is to seek out the factors that motivate these differences from both a political and economic perspective.

I have broken down my analysis into multiple sections. In the first section I discuss the history of Medicaid itself and in the preceding section explain the design and mechanisms of the program. I will then outline the puzzle of Medicaid in more detail to better establish the question I attempt answer. Next, I will examine the different social welfare theories in the abstract, followed by a recount of their previous applications to Medicaid through a literature review. After this discussion, I propose a new framework with which I will analyze Medicaid by utilizing

political ideology dominance and electoral competition, establishing testing methodology and the results of these tests. The essay concludes with a discussion and evaluation of my results and some final thoughts to what these results can tell us about Medicaid's future and US social welfare as a whole.

II. History

In 1965, Congress passed the Social Security Amendments of 1965, which contained two major pieces of legislation. The amendments arose out of President Lyndon B. Johnson's Great Society agenda and aspired to alter the state of social welfare in the United States, particularly in terms of health care (Stevens and Stevens 1974, 57). Title XVIII outlined the program of Medicare, which more or less is federal medical insurance for the elderly that taxpayers paid into during their working years (Stevens and Stevens 1974, 59). The new Medicare program garnered intense media attention and was "hand-crafted" by Representative Wilbur Mills (D-AK), author of the government's earlier foray into state health care under the Kerr-Mills Act (Olson 2010, 25). Medicaid, on the other hand, the focus of this essay, was established under Title XIX of the Social Security Amendments. Dissimilar from Medicare, the program received little coverage from the media, seen as no more than a standardization of current state programs as well as the earlier Kerr-Mills Act (Olson 24). The Kerr-Mills Act of 1960 outlined vendor-payments for indigent elderly receiving cash assistance or those elderly who were "medically indigent" (i.e. the deserving poor), run by the states with federal funding assistance (Stevens and Stevens 1974, 29). Mills, the writer of the Medicaid amendment, himself admitted that the program was hastily put together, borrowing much from the Kerr-Mills Act legislation regardless of its flaws; his and President Johnson's focus was trained on Medicare (Stevens and Stevems 1974, 58; Olson 2010, 26).

Although contemporaries show some disdain for the lack of forethought of these politicians, given the current state of Medicare and Medicaid, any essay attempting to address the issues of either of these programs must give attention to the environment in which these programs developed. Significant attempts had been made to create national health insurance in 1916, the 1930s, 1945 and 1949 under Woodrow Wilson, Franklin D. Roosevelt, and Harry Truman respectively (Hacker 2002, 121-2). Even, arguably, the most progressive liberal presidents in US history had tried and failed to extend government protection to health care. A variety of interests opposed the different attempts, most vocally of which were the American

Medical Association (AMA) and the conservative portions of Congress (Hacker 2002, 223-4). Basic arguments proposed by the AMA were federal restrictions being placed on medicine would weaken the institution and any such program would result in a reduction in their income (Hacker 2002, 227-8). Conservative politicians believed federal health care would weaken the nation, making more people reliant on the government, as well as the general "big government" expansion that would result from such a program; free market reasoning, even in health care, was popular with conservatives (Hacker 2002, 232). These movements, in one way or another, defeated all previous attempts at any national health care programs.

However, the playing field had changed by 1965. The staggering amount of elderly people struggling to afford their health care, which after Truman's attempt had become significantly more advanced and expensive, and the resulting increase of parents relying on their children for support, forced Congress and President Johnson to take notice (Stevens and Stevens 1974, 251-3). To alleviate these problems, liberals were finally able to defeat the AMA's opposition and sway conservatives, passing the Social Security Amendments. Again, as previously noted, the focus had been on Medicare, which conservatives and AMA conceded to due to its taxpayer funding and source of increased patients (customers), respectively; Medicaid was the sleeping giant no one paid real notice (Olson 2010, 24).

Within the very legislation, a distinction was made between Medicare and Medicaid that testifies to the difference in essence of the two programs. Medicare was created as a type of social insurance program, the government's promise to take care of the elderly after a specified time of work with citizens paying premiums into the system (Stevens and Stevens 1974, 52). Politicians sought to protect its citizens from the perceived ruthlessness of the free market in their old age; Medicare users were "beneficiaries," implying that they were enjoying rewards for their own personal hard work. On the other hand, Medicaid is characterized as social welfare medicine with a dependence/means test (Olson 2010, 27). The wording of the program reflects the societal contempt for those who cannot take care of themselves, who are not or have not worked hard enough to pay for their own health care. Users of Medicaid are referred to as "recipients," implying the opposite of Medicare; these people are simply getting something from the government they may or may not deserve. Furthermore, Medicaid recipients must subject themselves to a means test to prove they are, in fact, "too poor" to afford any reasonable amount of health care (Stevens and Stevens 1974, 61).

Therefore, readers must dispense with any altruistic or liberal notions about Medicaid in order to have any serious understanding of the topic. Medicaid, especially in comparison to Medicare, is not a crowning stone of modern American social welfare, but rather a fairly blunt attempt at health care for the poor to satisfy desires of Johnson's Great Society, to have some form of program rather than none at all (Stevens and Stevens 1974, 53).

Regardless, in 1965 soon after Title XIX's passage, both California and New York rushed to establish new state Medicaid programs to take advantages of benefits outlined in the next section (Stevens and Stevens 1974, 81-84). Other states held off on creating their programs, such as Arizona, who did not enact (limited HMO-form) Medicaid legislation until 1982 (Olson 2010, 58). Fast forward 47 years and the Medicaid programs in all their variety offer coverage to 60 million people, roughly 20% of the population, and spent a combined federal and state amount of $389 billion in 2010 (Kaiser Foundation, "Total Medicaid Enrollment;" "Total Medicaid Spending").

III. Purpose and Design

The general purpose of Medicaid is to provide basic welfare medicine in a state focused approach, with a focus on serving poor elderly, children, and families; not much assistance is offered to poor individuals. Furthermore, the federal government specifically allows Medicaid programs to extend coverage to the "medically needy," that is citizens who, by paying their own medical expenses, would place themselves within Medicaid income requirements (Stevens and Stevens 1974, 61-62).

Each state has its own unique Medicaid program with different coverage, benefits, and reimbursement rates, often beyond the federally mandated requirements (Coughlin, Ku and Holahan 1994, 9-10). However, each state is required to have some form of at least a minimum Medicaid program. Such a distinction, that each state establishes its own specific program, works to maintain federalism and keep federal involvement in health care low, both actions that were meant to appease the conservatives and AMA as outlined in the previous section (Hacker 2002, 245-6). Such a compromise comes at the cost of people's coverage being determined by geography, where a service that is covered in one state may not be covered in another and vice versa (Stevens and Stevens 1974, 60; Coughlin, Ku and Holahan 1994, 11).

Eligibility

Despite every state program being unique, there are federally mandated requirements they all must obey. First and foremost, all programs must extend coverage to those groups covered under pre-existing programs: families in AFDC (Aid to Families with Dependent Children), citizens 65+ years old, the blind, and the permanent/totally disabled. These four principal groups are referred to as the *categorically needy*, meaning their simple physical or social status qualifies them for Medicaid (Coughlin, Ku and Holahan 1994, 10). Most, but not all, states already had programs that previously covered these groups to varying degrees; Medicaid simply set a nation-wide standard for the states (Stevens and Stevens 1974, 63).

The legislation wanted to insure these protected groups were as complete as possible, hence Medicaid programs were required to cover the *categorically related needy*, that is people that would fall into these protected groups if not for specific state restrictions, usually related to age, residence, or harsh income requirements (Stevens and Stevens 1974, 62). The purpose of this category of recipients was to close the loophole that not all states originally had such protected programs, in essence "creating" them within Medicaid. Furthermore, it standardized the requirements for these categories to insure all group members would qualify in every state. Finally, also in this category of categorically related needy, are any individuals/families receiving cash assistance from the federal government, that is welfare recipients (Stevens and Stevens 1974, 62-3). However, this would be the extent of federal involvement in Medicaid program design; the national government only involved itself in the protection and preservation of the most vulnerable of society's members, the elderly, disabled, and welfare poor.

Although these two categories of people are the only required coverage groups, Medicaid is designed in such a way to encourage coverage beyond them. As will be discussed in the next section, state Medicaid funds will be matched at a rate of at least 50%. With this in mind, the legislation allows state's to cover the *categorically related medically needy* (Stevens and Stevens 1974, 63). This category includes "all individuals who would, if needy, be eligible for aid or assistance under any such State plan and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical or remedial care and services" (Stevens and Stevens 1974, 63). In short, Medicaid programs are permitted to cover children/families, elderly, blind, and disabled with incomes above those required for cash assistance. It is within this category states have the greatest flexibility in

choosing whether or not to extend coverage, making it the most relevant to this essay. However, the legislation also allowed for two key practices to be used by states. Each of these different classes could have different income requirements and states could also enact "spend-down" policies, requiring applicants to spend excess income until they hit the income requirement (Stevens and Stevens 1974, 64). One final caveat of Medicaid legislation is that federal funds would NOT be provided for any portions of a Medicaid program that cover *individuals* in between the ages of 21 and 65 (Coughlin, Ku and Holahan 1994, 10). Title XIX was clear in its intention: Medicaid was not intended to be a "catch-all" system for all economically deprived citizens who needed health care, only those most at-risk.

Benefits

States are required by the federal government to cover five main benefits in their Medicaid programs: inpatient hospital care, outpatient hospital treatments, laboratory work and X-rays, skilled nursing home care for recipients 65+, and physician services (Coughlin, Ku and Holahan 1994, 9). These services were determined by the federal government to be the most essential for adequate health care, but allowed federal funding for an additional ten optional benefits. These benefits include: medical/remedial care by other practitioners, home health care services, private-duty nursing care, clinic services, physical therapy, prescription drugs, dental health services, prosthetic devices, optical care, and diagnostic/preventative screening (Coughlin, Ku and Holahan 1994, 9). The different state Medicaid programs have expanded to include these optional benefits to varying degrees, with some including all and others only including a few.

The benefits themselves would be enjoyed via direct vendor payments; physicians, hospitals, pharmacies etc. would have to file with the state government to be reimbursed the value of the service they provided to a Medicaid recipient. Vendor payments for welfare medicine continued the precedent standardized by the Kerr-Mills Act (Olson 2010, 38). The Medicaid user themselves would never "hold" the funds from Medicaid, unlike regular welfare programs. However, individual states were left to determine the payment amount and schedule for Medicaid services, with only the vague federal guideline of reimbursement being based on "reasonable cost" (Stevens and Stevens 1974, 59). As a result, most Medicaid providers are often paid below cost or with minimal profit, leading to many benefit providers electing to not accept Medicaid patients; hospitals, however, must accept any and all Medicaid patients (Olson

2010, 39). Lastly, it must not be confused that these benefit packages are not nearly as lucrative as private insurance. The benefits covered are almost always far below even the most minimal private insurance benefit package. Medicaid is definitively welfare medicine, providing just enough to cover the absolute necessities (Olson 2010, 120-1).

Funding

The state and federal government provide funding for Medicaid jointly; the federal government matches state spending by a minimum of 50% and up to 83%, based on a formula involving the states average per capita income compared to the national average, a model borrowed from Kerr-Mills (Stevens and Stevens 1974, 59). More simply, the federal government at a minimum matches state-spending dollar to dollar and in the cases of poorer states, even more than that. The goal of the legislation was to promote poorer states to still have strong programs and create a modest level of Medicaid equality across the states (Gilmer and Kronick 2011, 1316). Most importantly, however, there is NO cap on the federal contribution to Medicaid programs, meaning state Medicaid programs can be as large or as small as states choose within the guidelines and still receive federal support (Gilmer and Kronick 2011, 1317). In essence, the larger the Medicaid program, the more "free" federal money brought into the state. It is important to note, that currently, Medicaid makes up the second-largest portion of state spending in many states or is competing for such position with public education or penal system administration, and is paid out of states' general funds (Snyder et al. 2012, 7) . In the original legislation, states were forbidden to charge Medicaid patients any sort of co-payment, but that has since been amended to allow for minimal co-payments to curb spending and program abuse (Snyder et al. 2012, 5). These payments, however, result in an insignificant portion of overall Medicaid funding, with the overwhelming majority still coming from state and federal government.

IV. The Puzzle

The basic construction of Medicaid emphasizes state choice. States can choose whom to cover beyond what is required by law, what extra services to provide benefits for, and choose the overall quality of these benefits. It is not surprising then, that state Medicaid programs vary widely on all of these variables. California has 30% of its population enrolled in Medicaid and New York has 27%, while Nevada and Utah have the lowest population enrollment of 11% (Kaiser Foundation, "Total Medicaid Enrollment"). The differences get even crisper when one

moves beyond simple enrollment numbers. The state of Alabama has an income requirement of 23% of the federal poverty level (FPL) for non-AFDC working families, which equates to a family of three with an income more than $4500 a year does *not* qualify for Medicaid in Alabama. At the same time, Maine, New Jersey and Wisconsin have an income requirement of 200% FPL; in other words, any family making less than $39,000 is Medicaid eligible (Kaiser Foundation, "Adult Income"). At face value, this difference is striking in itself. Although the cost of living varies from Wisconsin to Alabama, one cannot explain away a gap of $34,500 that easily.

Moving beyond who simply qualifies, state expenditures on Medicaid vary to an even higher degree. New York spent $52.1 billion in 2010 compared to $687 million in North Dakota, although these are too fairly dissimilar states. Maine and New Hampshire are both New England states of fairly equal population (approximately a 9000 person difference), yet Maine outspends New Hampshire $2.3 billion to $1.3 billion, a 100% difference. Furthermore, their GDPs are backwards, meaning New Hampshire is actually *wealthier* than Maine ($55.7 billion compared to $40.6 billion), eliminating the possible explanation Maine spends more because it has more wealth (Kaiser Foundation, "Total Medicaid Spending"). This brief comparison between Maine and New Hampshire is not the only case of stark differences in spending despite having similar other factors.

The data, then, begs the question: what explains these large differences between Medicaid program "strength?" What factors play a role in deciding how expansive (or restricted) a Medicaid program will be? By applying the traditional theoretical models of social welfare policy, that is the functionalist-economic theory and the social-democratic theory based mainly in previous literature, as well as my own framework involving politicians decision making being motivated by ideology and the level of electoral competition faced, the goal of this essay is to discover why these programs are operated in such a way. Does a state's economic strength determine the state of its Medicaid program or does the level of political liberalism within the electorate/legislature or finally, does the risk to a politician's reelection in conjunction with their ideology have the most influence? As a self-proclaimed program of "welfare medicine," is the answer as simple as Medicaid follows trends similar to that of other US welfare programs or is it something unique given its role as a health care provider and state control? By evaluating Medicaid through these different theoretical lenses, using each program's total expenditures,

expenditure growth rates, and income eligibility requirements as a measure of "strength," we can hope to achieve a clearer view of this important US welfare institution.

VI. Literature Review, Theories, and Hypotheses

The Social Welfare State

The social welfare state is a topic of considerable research in political science, reinforced by the fact that all modern industrial democracies fall into this category. At its most basic level, the social welfare state is "the product of the interplay between political equality (democracy) and economic inequality (capitalism)," that is a conscious attempt to "balance the system" (Van Kersbergen and Manow 2008, 521). The welfare state exists as a materialization of the philosophy that a democratic state, beyond civil and political rights, works to insure social protection as a third right attached to citizenship (Van Kersbergen and Manow 2008, 522). Later research has criticized this "state-centered approach," instead claiming the welfare state serves as a risk management system. As capitalism causes risks to aggregate, said risks become *social* risks, affecting society as a whole and putting them in the realm of political struggle (Van Kersbergen and Becker 2002, 188). They enter politics as they are shared by many people, are perceived as a threat to certain segments of society, and are beyond the control of any one individual. New social risks, such as unemployment, old age, and protests against ruling classes, all arose out of the new capitalist democratic states and the welfare state is the organized response to such risks. Classical normative thought held that capitalism and democracy were naturally at odds with one another and incompatible, but time has proven high social spending is not necessarily detrimental to market competitiveness and a generous welfare state can exist within a capitalist economy; countries such as Sweden are indisputable evidence (Van Kersbergen and Becker 2002, 194-5). Furthermore, in post-war democracy, the welfare state has become a "fundamental structural component" and has been highly resilient to changes in the socioeconomic and political playing field caused by aging populations, unemployment, and globalization, speaking to its compatibility with capitalism (Van Kersbergen and Becker 2002, 186).

It is due to this fundamental and resilient status that the welfare state continues to be highly studied by political science. Early research sought to answer why welfare states developed in attempts to uncover what conditions were required for such an institution to be created. As welfare states progressed, attention shifted to studying the growth of these welfare

programs and their relationship with the overall economy, programs of other countries, and most importantly, politics. These two categories easily overlap, with the same players being effectively involved in answering both questions; what or who were pivotal in causing and growing the welfare state: social classes, labor movements, historical legacies, wars, economic development, demographic pressures, or employer interests (Van Kersbergen and Manow 2008, 521)?

There are three primary fields of social welfare theory, all seeking to answer these questions. The functionalist approach involves the state's answer to the growing needs of citizens in an industrial economy, relying primarily on economic forces for explanation. Alternatively, the social democratic (or class mobilization) perspective views the welfare state as the result of battles between social classes and their sources of political power, that is labor movements, special interests, or political parties. Finally, the institutionalist theories reject economic and social forces outright, arguing that the institutions (rules and regulations) operate autonomously and they alone determine the size and scope of the welfare state (Van Kersbergen and Becker 2002, 188-9, 199-200). Each of these overarching theories have more specific and developed perspectives, but only the functionalist and social democratic theories will be addressed in the following sections; there is little existing literature involving Medicaid and institutionalism.

Functionalist/Economic Theories

From the functionalist (or economic) theory perspective the core concept is that the welfare state operates as a "political function of legitimization," in other words equating welfare programs to tools that level the playing field just enough for capitalism and the government to appear legitimate; the inequalities of the system are overlooked. Furthermore, the economic theory recognizes that the free market cannot solve certain social issues (i.e. poverty and health care) and the state instead, must work to rectify these issues. As Van Kerbergen and Manow explain, socioeconomic development and technological growth create social problems that must be solved by governments, regardless of the type of political system or ruling coalition; modernization and industrialization give rise to the welfare state as these forces erase the traditional means of subsistence and mutual assistance (2008, 523-4). As a state industrializes, its social programs become more advanced, creating a stronger social security net to "catch" those who fall through the system (Van Kersbergen and Manow 2008, 524). Industrialism

encouraged modernization of society, more specifically the free labor contract and the resulting loss of income security. As the economy developed, the traditional sources of social security disintegrated; kinship ties weakened, the agricultural economy weakened, and guilds closed their doors.

A stronger (more industrialized) economy can support a state that can assist its less fortunate citizens and within this falls the "logic of industrialism" argument, that is citizens of the state expect as they take on the greater risks of a capitalistic system, the state will protect them as the state as a whole moves towards greater wealth (Van Kersbergen and Manow 2008, 525). Welfare states develop out of the citizens' tradeoff of economic security with the greater overall benefits to society as a whole. The higher a state's income, the stronger their welfare programs will be. The government utilizes its higher tax revenues from a stronger economy to support these new programs in order to address these problems with capitalism. Democracy provides the societal motivation for the extension of this "third right" of social protection while capitalist success provides the funds to do so. Another take on the functionalist theory, logic of capitalism, postulates that welfare programs evolve to preserve the interests of "capital" or the capitalist elite; a healthy, happy labor force works better and with less complaint, furthering the profit margins of the economic and social elite (Van Kersbergen and Becker 2002, 189). The difference between these two economic perspectives then is what welfare state development is a response to. Logic of industrialism argues welfare programs are a response to citizens' need of social protection and government's "patriarchal" role in providing such protection. On the other hand, logic of capitalism explains that the welfare state is in response to capital holders demands, that they need protection for their workers, but they do not want to supply it themselves. The government must then step in and supply such programs to keep capital interested in maintaining their presence in the country by providing a happier, healthier, more secure workforce. These two perspectives share a similar theory, that economic needs create or develop welfare states, but differ on the motivator: government patriarchy for the citizenships' needs or capital demands.

Functionalism and Medicaid

Moving on to the focus of this essay, other scholars have explored the functionalist avenue in an attempt to explain variances in state Medicaid programs, with a primary focus on the wealth of the states, measured by either total state GDP or per capita income (Buchanan, Cappelleri and Ohsfeldt 1991, 68). Said research follows primarily the logic of industrialism

approach, that as the states' economies develop and result in higher incomes, social welfare programs become stronger, particularly Medicaid. Previous research has shown that a direct relationship exists between per capita income and total Medicaid expenditures; a 1% increase in incomes results in a 0.25% increase in expenditures (Buchanan, Cappelleri and Ohsfeldt 1991, 70). This same study by Buchanan, Cappelleri, and Ohsfeldt also found that a 1% increase in the number of Medicaid recipients created a 0.5% increase in expenditures, but this however is rather unsurprising (1991, 70). Having more people in the system and collecting benefits will naturally increase the costs of the program as a whole. In his synthesis of a wealth of social welfare research in the US, Edward Alan Miller confirms these results, that incomes are positively related to the level of Medicaid provision (2005, 2647).

While at first, this would seem to prove that economic factors are a strong indicator of program strength, Buchanan et al. and others make two false assumptions. Foremost, they include total program expenditures as their only dependent variable, assuming it is the best indicator of program strength. This assumption neglects the overall variance in pricing across the states; a hospital stay in New York does not cost the same as a stay in California (Holahan 2007, 667-8). A highly thorough study sponsored by the Kaiser Family Foundation elaborates on even further explanations for cost differences, such as the level of demand, the age of the recipient population, access to care, and the health care provider supply, all being at different levels in the states and influencing pricing, weakening the significance of expenditures as a measure (Snyder et al. 2012, 8-18). Such a point is furthered by the wide variance in per enrollee spending, expressing the price differences as well as the quantity of services offered. A state that offers an expensive dental plan will have higher expenditures, regardless of enrollment. The second assumption made by previous scholars is that dollars are the only accurate descriptor of Medicaid program strength, ignoring others such as FPL percentage income requirements, the number of benefits offered, and the overall expenditure growth rate of Medicaid. Holahan also points out that some states have a larger impoverished population than others, despite the possibility that states have similar per capita incomes; a larger impoverished population will mean more Medicaid users and therefore higher expenditures based purely on volume (2007, 668). In short, major efforts to show the functionalist theory applicable to the Medicaid question, despite promising results, have rested on assumptions that cause them to fail to provide a complete answer; economics may not be the end-all explanation given the gaps shown here.

Social-Democratic Theories

Political scientists, in hopes of explaining Medicaid, have also utilized different aspects of the social democratic theory. Within this theory the focus is on the political, ideological, and social forces that can work to mold social welfare choices. However, social democratic theory is a very general overarching idea. As states have developed, political science has questioned different assumptions or proposed new ideas, resulting in a diverse field of social democratic theories, which are not all mutually exclusive, but take varied approaches to answering social welfare problems in a socially democratic manner (Van Kersbergen and Becker 2002, 189-191).

Arising out of the discovery that the presence of democracy alone is not a strong enough force to create social welfare programs, the class mobilization theory posits that three preconditions are required: a weak right/conservative movement, union strength and cohesion, and building of political coalitions (Van Kersbergen and Manow 2008, 527). The presence of these three conditions working together shifts power to the working class and their representatives, that is the party of "labor." Each of the components serves a different purpose; conservative movements naturally work against such expansions, making their disorganization critical, labor unions serve as an organizational unit and voice, and the ability to form a coalition between these unions and labor in general allows for the formation of demands and policy (Van Kersbergen 2002, 190-1). With these forces united, social welfare programs will be stronger and more extensive as they benefit these groups (labor and the impoverished) the most. This class mobilization idea can be characterized equally well as power resource theory, given the amount of resources each group has determines the amount of power they have in shaping policy. Furthermore, much literature has been devoted to the concept of "decommidfying labor," providing temporal relief to labor from the pressure of selling itself on the free market at "market value" (Van Kersbergen and Manow 2008, 524-7). Social welfare stands as the measure of the success liberal/labor powers have had in doing this, allowing to make up the difference between the pure value of labor and what is required to comfortably live. In contrast to functionalist thinkers then, social welfare is a political manipulation of the system to provide *relief*, rather than the safety net that functionalists proposes social welfare serves as; social democrats argue the problem already exists, while functionalists only concede there stands a *risk* for such a

problem (Van Kersbergen and Becker 2002, 200-1). At its core then, the theory promotes the conclusion that states with more powerful (and active) social classes, interest groups, and political parties supported by these three forces, will create stronger welfare programs.

As parties have grown stronger in democratic governments, another perspective known as the "political partisan perspective" has arisen. The theory is effectively a condensed and more practical version of the power resource theory, positing that when right-wing parties control government there will be less social welfare than when a left-wing party controls the government (Lee and Donlan 2009, 200-1). The ideology of the different parties is given greater consideration rather than the constituency of each party, as classical power resource theory does. Granted the likely ideology of each constituency is fairly easy to predict, but this perspective follows more closely the ideology of the government in power, rather than the voters that elect them into such positions (Lee and Donlan 2009, 197). Dovetailing from this idea, in terms of relative social welfare, the *more* right-wing a right-wing party in power is, the less social welfare there will be in comparison to other right-wing parties (Van Kersbergen and Manow 2008, 533). However, this perspective also includes an important exception. If a party has long-standing control of the government, their adherence to their ideology may weaken by either allowing more or less social welfare than their ideological position would normally dictate, the argument being that dominant parties have less fear of electoral backlash and can drift towards more moderate and less costly positions without risking their control (Barrilleaux, Holbrook and Langer 2002, 417).

Although the political partisan perspective is lauded for its simplicity by focusing on party or politician ideology rather than the varying desires of different societal groups, there still exists a indirect counter-theory known as the nonelectoral politics perspective (Van Kersbergen and Manow 2008, 530). Here it is theorized that it is not the politicians and their parties that dictate the level of social welfare, but rather organized interest groups and social movements. Through their pressure on those in power, social welfare is expanded or contracted, regardless of the ideological stance of those in power. Having elected officials on your side helps, but not a necessary condition; organized pressure can still push welfare policy in the desired direction (Barrilleaux, Holbrook and Langer 2002, 418). Proponents cite as evidence the substantial gain in social policy seen after large protests and the resulting political crises such as cash assistance payments to handle problems with high poverty. In short, both organized interest and strong

social movements are the primary drivers of changes in social welfare policy (Barrilleaux, Holbrook and Langer 2002, 418).

Within social democracy literature there also exists a core structural argument in explaining social welfare: risk redistribution theory. Risk redistribution theory rejects the fundamental idea of social welfare's goal as income equality, and instead suggests social welfare focuses on the reapportioning of risks (Van Kersbergen and Manow 2008, 528-9). In rejection of class mobilization, a core assumption is that the working class is *not* the only at-risk segment of society, with risk groups cutting across multiple classes; social welfare is not labor's victory over capital. It is not labor's power or influence alone that determine policy, but also capital's recognition that they "share a common interest in reallocating risk with the disadvantaged;" the failure of a business due to an ineffective work force affects both societal groups (Van Kersbergen and Manow 2008, 529). By pooling their risks, all of society could stand to benefit resulting in equality and by extension, social welfare programs. Therefore, risk redistribution's greatest contribution to social democratic theory is that the drive for social welfare does not necessarily reside in the working class, but can stem from a pooling of risks from varying segments of the society/economy (Van Kersbergen and Manow 2008, 530).

I again reiterate that each of these perspectives are not exclusive stand-alone theories, but rather add to the social democratic conception as a whole. Depending on the nation or program in question, different perspectives may be more useful than others. The perspectives as a collective, however, still hold the same basic premise that social and political forces motivate social welfare policy, not just economic factors as functionalism would suggest.

Social Democracy and Medicaid

The most direct application of social democratic theory to Medicaid tests the level of liberalism within state legislatures compared to their Medicaid expenditures. Previous researchers then, in more abstract terms, attempted to apply both the political partisan perspective and the class mobilization theory to Medicaid. Contrary to most researchers predictions, no strong relationship arises between these factors and Medicaid expenditures. Buchanan, Cappelleri and Ohsfeldt in their analysis of Medicaid found that liberalism indexes have no correlation with Medicaid expenditures (1991, 71). The authors effectively conclude that politics has no influence in spending and by extension Medicaid program strength without much further investigation (Buchanan, Cappelleri and Ohsfeldt 1991, 71). Again in his synthesis

work, Miller cumulates all work done on Medicaid and liberalism indexes. The results of his research show no statisically significant relationship between ideology and Medicaid spending, but notes that liberal *public opinion* is positively correlated with higher eligibilty (Miller 2005, 2648). There would seem to be other forces at work in relation to government ideology and Medicaid program strength, as if liberal public opinion is a driver, it would be logical for a liberal government to influence Medicaid outcomes in a similar fashion. In another analysis, Miller's work shows support for electoral competition having a positive relationship with higher levels of Medicaid; divided governments seem to have a negative relationship with Medicaid spending (Miller 2005, 2648). However, Miller does not take ideology into account on either of these analyses, an important distinction. In short, studies have shown some correlation at varying levels, but nothing concrete or investigated thoroughly enough to generate a complete explanation of political factors' role in Medicaid policy.

All of these same studies also make the same mistake as most functionalist tests, making expenditures the only dependent variable. Expenditures, as noted previously, are not the only indicator of Medicaid strength and may in fact not even be the best indicator. Furthermore, the variable of liberalism is not tested in conjunction with the level of electoral competition, which other works have proven to be the better predictor of policy outcomes, especially in the US (Barilleaux, Holbrook and Langer 2002, 418). If electoral competition is high, candidates need to solidify their base as well as persuade median voters (Barilleaux, Holbrook and Langer 2002, 419). On the other hand, if electoral competition is low, legislators have no strong motivation to sway voters, as they will win anyway and few members of the electorate change sides; party identification has been shown repeatedly to be a fairly ingrained behavior (Barilleaux, Holbrook and Langer 2002, 422; Hershey 2013, 112-3). As Holahan again explains this type of research works to only prove one thing: programs come down to state politicians' willingness to pay for them, not their political ideology (2007, 669). Despite attempts to show that, as legislatures become more liberal/Democratic, that is more socially democratic, their willingness to strengthen Medicaid increases, this relationship has failed to materialize.

Proposed Framework

The weakness then of previous literature is evident. Functionalist theory neglects other indicators for Medicaid strength assuming expenditures is the only real measure available; social democratic theory makes this same mistake as well as ignoring that liberalism's influence on

policy is better measured when used in conjunction with electoral competition. Both theories neglect the role that competition and median voters play in forming policy. However, these theories' weaknesses leave an opportunity to make another attempt at the Medicaid question, by better using the political partisan perspective and electoral competition as well as incorporating improved dependent variables that more accurately measure Medicaid program strength. As noted before, previous research shows liberalism[1] and electoral competition[2] are strong indicators of policy outcomes, but have yet to be applied to Medicaid specifically; previous work has mainly involved "liberal policy" in general, not a particular portion of social welfare policy (Barilleaux, Holbrook and Langer 2002, 416).

Expanding upon the argument made above, I propose an interaction framework between liberalism and electoral competition; the level of these two factors working together or against one another will help dictate social welfare policy, specifically Medicaid policy. Such an interaction, in essence, utilizes both the partisan perspective of power resource theory and electoral competition as its theoretical foundation. In theoretical terms, my proposed framework follows this logic. Power resource theory dictates that the party/ideology in power will pursue its desired goals as much as possible, with liberal/labor groups specifically working towards social welfare programs. The relative power of the liberals determines how far social welfare policy will go, with more influence and power resulting in broader expansions. The electoral competition concept holds that as competition for the legislature increases, both sides must work to sway median voters by moderating their views, rather than simply rely on their typical base of support. The two factors act as a check against one another; politicians can only pursue their ideology as far as long as the level of electoral competition permits it.

Given my proposed framework, if a state legislature is highly liberal, but faces little electoral competition they will support welfare programs wherever possible. With their electoral

[1] The terms liberal and conservative require some clarification. Both of these terms refer to support for/against programs such as welfare, Medicaid, gay marriage, abortion, "big government," economic intervention, and other entitlement programs; any movements to support these items is "liberal," those against are "conservative." Such a term speaks to the ideology of the government in power.

[2] Qualitatively, competitiveness refers to the level of difficulty within the state to be elected if one is of a certain party and maintain that office once elected. Quantitatively, competition is measured via the Ranney Index.

dominance assured, there is little to no backlash in the enactment of these policies, as they will win reelection regardless of such strong liberal policies. It is assumed the conservative party has no opportunity to usurp control, leaving the liberal party to expand welfare as they see fit (without drifting into socialism of course) (Barilleaux, Holbrook and Langer 2002, 424). On the other side of the spectrum, conservatives that enjoy electoral dominance in a conservative electorate do not have to support welfare; neither the electorate nor their ideology compels them to do so and there exists no strong liberal movement to stop them. The core assumption then, is that either dominant party's political base is larger than the pool of swing voters in a non-competitive state; here power resource theory shows itself, as the party in power pushes its own agenda (Barilleaux, Holbrook and Langer 2002, 424). The contentious middle ground then, lies in a window between these two extremes, where electoral competition is high enough to conduce legislators to support popular welfare programs in order to win votes (Barilleaux, Holbrook and Langer 2002, 419).

It is around this window my own framework coalesces towards an answer to the Medicaid question. Previous attempts to answer the Medicaid question have been incomplete due to poor assumptions or an acceptance of results without further investigation. Having explained the more traditional theories' weaknesses, I now turn to my own framework that endeavors to provide an explanation for the huge variances in Medicaid programs across the states, taking advantage of the gaps in previous literature. One of politicians' primary motivations is a desire for reelection, an effort both party members of varying levels of ideology can be accused of. To be reelected, at the risk of sounding urbane, politicians need more votes than their opponents; the risk of falling short of the necessary votes to win reelection is more prevalent in competitive state elections. The votes that are contended are of median voters, those who do not fall squarely in either the liberal or conservative camp. They have no strong ideological or party attachments, but are instead motivated by either economic concerns or more moderate social values. However, politicians are not powerless in gaining these median votes, having a variety of tools at their disposal with which to "win" votes. Most would turn to campaigns as the strongest tool available to politicians to sway median voters, but politicians also have access to another tool, one more relevant to this essay: policy. Through either policy suggestions by non-incumbents or policy-making records for incumbents, politicians can utilize policy to win votes. Following this logic, liberals will support Medicaid to solidify their base as

well as win median voters. Conservatives will support Medicaid expansions to attempt to gain these same median voters with the risk of losing reelection forcing them to move beyond their ideological comfort zone. The assumption here is that, on a social level, the median voter does not want to weaken welfare programs, but rather expand them to include more people; they find themselves benefitting from them themselves or see it as a "social good" worthy of promotion. Regardless of their motivation, politicians stand to gain more ground with median voters by supporting welfare policies rather than opposing them.

Medicaid policy can be utilized even further to win median votes by both sides via economic motivations. Depending on the state, Medicaid can bring in hundreds of thousands to millions of dollars of "free" federal money into the state, to support an ever-growing medical industry, creating new consumers in the impoverished and disabled. Since 1960, the medical industry has expanded from 5 percent of GDP to more than 16 percent in 2006, and is estimated to pass the 20 percent marker by 2015; the US has real economic reliance on health care (Olson 2010, 203). Additionally, Medicare, Medicaid, and SCHIP collectively account for nearly half of all health care spending (Olson 2010, 203). If one does the math, federally supported health care makes up 8 percent of the *entire* US economy. Beyond the simple purchases of Medicaid dollars, there exists a multiplier effect which, according to Families USA, results in for every $100 million states invest in Medicaid the state to see a $335 million return in new business, a 335% return rate (Olson 2010, 204). Across the board, research has shown the positive effects of Medicaid dollars in state economies. Studies in South Carolina, Ohio, and Michigan have shown that if the states took a 5 percent cut in their Medicaid programs, the resulting job loss would be roughly 32,700 jobs between the three of them (Olson 2010, 204-5). In areas hardest hit by the decline of the manufacturing sector, like the automotive industry in Detroit or coal mining in Kentucky, Medicaid serves as the largest source of outside capital in order to bolster new economic enterprise in health care (Olson 2010, 205). Although Olson uses these figures to argue the reasoning behind a lack in any real Medicaid program cuts, one can extrapolate that with such positive economic power behind Medicaid dollars, politicians, particularly state politicians, can use Medicaid to please constituents and bring them jobs; voters are likely to support the politician that got them back to work. The more competitive a district or state is, the more likely a politician will be encouraged to use this type of political tool to win votes, particularly those of median voters insulated from or wary of moderate social pressures.

Both sides, by supporting Medicaid expansion, will also enjoy the gratitude of medical industry interest groups, powerful groups that actively lobby governments and donate to campaigns. Earlier research concerning the power and presence of medical industry interest groups and Medicaid has found the more the influence of such an interest group, the larger the amount of Medicaid expenditures, explaining the possible outlier of conservative politicians in moderately uncompetitive states supporting Medicaid in trying to gain these groups support (Buchanan, Cappelleri and Ohsfeldt 1991, 71). These interest groups typically express their gratitude towards supportive politicians with large campaign donations, a valuable asset to all legislators.

Lending further evidence, research shows states rarely spend less on Medicaid than the previous fiscal year (Schneider 1988, 760). Motivating such decision-making is again the specter of vote loss and the risk of "political suicide;" supporting Medicaid *contraction* could destroy a Democrat in the primary or a Republican in the general election. Expansion is the issue here, as all evidence points to it being the only way Medicaid can be used as a tool.

The incentives (and disincentives) for supporting Medicaid to politicians facing electoral competition are clear. In short, the decision to either support or oppose expanded Medicaid program strength may be fixated on attaining votes either through social value appeals or economic motivation to more insulated voters, with heavier usage in more competitive electoral politics.

Proposed Framework Hypothesis

Moving towards a more testable model, I will utilize the rather simple two by two diagram shown in *Table 1*. One axis will contain the ideology variable while the other will use the electoral competition variable. To measure state legislature ideology I will utilize a scale developed by Berry et al. that measures liberalism of all political players, which are then weighted based on power to influence policy decisions, meaning the governor has more power, and therefore more weight, than a state representative; the liberalism scale ranges from 0 to 100 with 100 implying the highest possible level of liberalism (Berry et al. 1998, 332; Fording 2012). The standards set in their work "Measuring Citizen and Government Ideology in the American States, 1960-93" has been maintained and updated by one of the original authors, Richard C. Fording, and aggregated by Georgetown University in their StateMinder data tool (Berry et al. 1998; Fording 2012). In regards to the framework to determine if a state falls into either the

liberal or conservative category the cut-point will be at 50. Any state with a value of greater than 50 will be liberal, any state less will be deemed conservative. The popular Ranney Index, meanwhile, will be used to measure electoral competition. The index, named after its creator political scientist Austin Ranney, measures competitiveness within state elections by averaging three key indicators: "the percentage of the popular vote for the parties' gubernatorial candidates, the percentage of seats held by the parties in the state legislature, and the length of time plus the percentage of the time that the parties held both the governorship and a majority in the state legislature" (Hershey 2013, 29-30). The index ranges on a scale of 0 to 1, with 0 equating complete Republican control and 1 equating complete Democratic control. Its beauty is that it accounts for aggregate changes in competition over time each time it is calculated, meaning the latest data set accounts for the state's history of competition or lack thereof. The cut-points concerning the Ranney Index are more complex, as a 0.5 value denotes perfect competition. Here, any state with a value assignment between 0.35 and 0.65 will be placed in the high competition category. States that fall below 0.35 or above 0.65 will herein be considered low competition states. These two axes serve as the independent variables of the model.

Table 1

Ideology vs. Electoral Competition	Low Competition C > 0.65 **or** C < 0.35	High Competition C < 0.65 **and** C > 0.35
Conservative Majority L < 50	-	+
Liberal Majority L > 50	+++	++

Before I proceed to discussing the dependent variables used to measure Medicaid strength, however, I must make a caveat to the interaction model in terms of *levels* of Medicaid expansion and support. Although I have suggested for the reasons outlined above, that Medicaid will be supported dependent on the four different framework "categories," that level of support will be higher or lower relative to the other categories, dependent on the category. In other words, a liberal dominated legislature with little electoral competition will have the highest levels of Medicaid support, hence these states should have the strongest Medicaid programs. Second, a legislature with a liberal majority that faces high electoral competition will have higher levels of Medicaid support than a conservative majority that faces electoral competition,

as such support falls more naturally in their ideology; conservatives will only want to drift left just as far as is necessary to win. Therefore, states with liberal legislatures with high electoral competition will have stronger Medicaid programs than states with conservative legislatures in the same position, but neither will be able to match the strength of a liberal dominated state. Finally, for completions sake, a conservative legislature with little electoral competition will have the weakest support for Medicaid and will therefore have the weakest Medicaid programs. Referring back to *Table 1*, these distinctions are indicated via – and + signs; the number of + signs designate the relative levels of Medicaid support.

With that clarification I can proceed in outlining the two primary dependent variables: income requirements for Medicaid eligibility and growth rate of Medicaid expenditures. Each state sets an income threshold for Medicaid eligibility for low-income families based on a percentage of FPL (Snyder et al. 2012, 20). A higher percentage means a family can have a higher income and still qualify, making the Medicaid program more encompassing of the lower class in the state, and by extension stronger. Such a measure is stronger than simple spending as it represents a clear decision by the legislature how much they value welfare medicine, by determining who does and does not qualify. Furthermore, it is a distinction that is easily consumable. A state program with a 200 percent FPL requirement is obviously far more inclusive and stronger than a state with a 23 percent requirement. The measure also avoids the influence of pricing discrepancies, demand levels and other factors that affect simple expenditures. If the framework holds true, the percentage ceiling will be highest in the liberal dominated states, followed by the liberal majority contended states, then the conservative majority contended states, and lowest in the conservative dominated states.

The other dependent variable I will use is the states' Medicaid expenditure growth rate. Every state started at a different expenditure level, depending on the benefits they initially decided to include, making direct expenditure comparisons over time difficult; the decisions of the initial legislature that designed the program could systemically skew the data. Furthermore, as I have noted repeatedly, expenditures alone are unduly influenced by price differences and a myriad of other factors. By utilizing a growth rate, that is comparing expenditure growth within the state itself over time, the price differentials drop out and enrollment levels become a nonissue. To maintain simplicity and manageability, I will use growth rate data from the past twenty years (1990-2010). In regards to this variable, again if the framework holds true, the

growth rate will be highest in the liberal dominated states, followed by the liberal majority contended states, then the conservative majority contended states, and lowest in the conservative dominated states.

VII. Methodology and Results

Methodology

In order to apply the proposed frameworks to the states, I utilized data from 1990-2010. For the independent variable state legislature ideology, I took data from StateMinder, a data tool created by Georgetown University, taking the average ideology over the entire time period; the source data is Fording's continuation of the methods set in his previous work (Fording 2012). The other independent variable, the Ranney Index, I again used StateMinder, but only had to use the most recent data, as the index has time variations built into its computation; the Ranney Index data set was compiled by Stefanie Linquist in *State Politics and Policy Quarterly* (2012). Following the standards set in the previous section, the different states fall into their respective categories, shown in *Table 2* below.[34]

Table 2

Ideology vs. Electoral Competition	Low Competition C > 0.65 or C < 0.35	High Competition C < 0.65 and C > 0.35
Conservative Majority L < 50	- AL, AK, AR, FL, ID, KS, MS, MT, NH, OH, SD, UT, WV, WY	+ CO, GA, IL, IN, IA, MI, MO, NE, NC, ND, OK, PA, SC, TX, VT
Liberal Majority L > 50	+++ CA, HI, MD, MA, RI	++ AZ, CT, KY, LA, ME, MN, NV, NJ, NM, NY, OR, TN, VA, WA, WI

To test the dependent variable growth rate, I collected data from the Henry J. Kaiser Family Foundation sponsored statehealthfacts.org, which includes diverse and thorough data on Medicaid programs ("Average Annual"). For simplicity's sake, as well as to more accurately

[3] Delaware and District of Columbia were excluded, as full data was not available.

[4] See Appendix 1 for the full data.

compare each state relative to its proposed position in the interaction model, I took the average growth rate over the 1990-2010 time period. Income requirements for Medicaid eligibility, the other dependent variable, again uses data from the Henry J. Kaiser Family Foundation, however only one set from 2010 ("Adult Income"). Since states rarely maintain databases of past requirements, they are difficult to find reliably. However, this is a non-issue as states will rarely (if ever) contract their Medicaid programs, that is tighten income requirements; as I outlined before any Medicaid contractions are "political suicide." By applying these two data points to the model, I will test to see if the classifications made by the interaction model, that is electoral competition and ideology, explains differences in Medicaid program strength. In other words, I will, for example, test to discover if the states in the conservative majority high competition category score higher on the dependent variables than those states in the conservative majority low competition category.[5]

Results

As outlined above, I tested my framework on two different variables, Medicaid expenditure growth rate and income requirements for Medicaid eligibility. The tests yielded different results for both variables.

Put simply, on the variable of growth rate, no pattern emerged within the framework and no statistically significant differences between the means (at $p < 0.05$). In taking the average growth rate of all states in each respective category, no clear trend emerged. Looking to *Table 3*, one can see that states with a conservative majority and low competition had an average growth rate of 7.47% from 1990-2010, but states with a liberal majority and low competition had a growth rate of just 7.8% over the same time period. Clearly, in terms of this variable, electoral competition and ideology are not accurate predictors of Medicaid strength. I had expected to see the greatest disparity in growth rates between these two groups, but the model shows only a 0.33% difference. Furthermore, the liberal majority states with high competition had a 0.41% increase *over* the "safe" liberal states. Although high competition conservative states had a higher average than low competition conservative states, the difference is fairly negligible at only 0.33%.

However, the model does hold true when tested for income eligibility requirements, shown in *Table 3*. The average income requirement rate for each category follows the expected

[5] See Appendix 2 for the full data.

pattern set by the framework, albeit the relationships were not as strong as I hoped and there are outliers in each category with Ohio, Virginia, Texas, Indiana, and Louisiana being the biggest offenders. Regardless conservative low competition states had an average requirement of 45.71% while low competition liberal states had an average of 135.0%, a statistically significant difference ($p = 0.005$). However, while the low competition conservative states on average had a requirement of 45.71% of FPL compared to the high competition conservative states, which held an average 71.47% of FPL requirement, a 25.76% difference, these means were not statistically significant ($p = 0.945$), but the difference still follows the correct pattern. Furthermore, the high competition liberal states scored at 118.27%, a difference from the low competition conservative states that was highly significant ($p = 0.001$), as the framework predicted. The difference between the two high competition categories also showed support for the proposed model, with their mean differences significant at $p = 0.050$. Therefore, in terms of predicting how strict a state will be in allowing citizens into Medicaid, electoral competition and ideology can be utilized as a *general* predictor of where a state will fall, albeit with exceptions which I will discuss more thoroughly in the next section.

Table 3

Ideology vs. Electoral Competition – Growth Rate	Low Competition	High Competition
Conservative Majority	- 7.47%	+ 7.8%
Liberal Majority	+++ 7.8%	++ 8.21%
Ideology vs. Electoral Competition – Income Requirements	Low Competition	High Competition
Conservative Majority	- 45.71%	+ 71.47%
Liberal Majority	+++ 135.0%	++ 118.27%

VIII. Discussion

The Medicaid puzzle I originally posed revolves around the drastic differences between the 50 states and DC, despite having the same federal guidelines. My proposed framework

sought to shed light on the factors behind these differences, particularly the influence of political ideology and electoral competitiveness. From my tests it can be concluded that these two factors do indeed play a role in Medicaid, but not in the way I had originally anticipated.

As the test shows, competitiveness and ideology are not accurate predictors of the growth rate of Medicaid expenditures. Rather than destroying the framework, I instead believe it exposes a weakness that helps explain politicians' feelings toward Medicaid. In general, in order to spend more money on Medicaid, the government must add benefits (or increase the size of existing benefits) or drastically increase membership. Either or both of these actions will effect the growth rate, but explicitly cost the state more money reflected in a larger Medicaid budget, resulting in spending cuts in other areas, higher taxes, or running a deficit in order to fund it. Politicians, despite their ideology or the risk to their reelection, the model would imply, view the costs of expanded Medicaid as too high. The ability to maintain a balanced budget or avoid taxes/deficit could be, from the perspective of politicians, a more valuable and effective tool to win reelection. Perhaps politicians believe other policies are more effective to use as tools in contested elections than Medicaid such as more general tax cuts or education subsidies to name a few, despite the demonstrated economic benefits of Medicaid expansion. It would seem the "political" cost of Medicaid is too high to rationalize the financial costs such expansions would pose. Perhaps the economic benefits outlined by Olson occur in too long a time frame for politicians to effectively utilize them.

However, given the test concerning income requirements for Medicaid eligibility does maintain the framework, I believe we have simply looked at Medicaid as a tool in the wrong way. Rather than being an economic argument, that is using Medicaid to bring in jobs and money to the state, politicians utilize Medicaid as a social argument. The social argument politicians can make with broader income requirements is that they support helping the impoverished while not necessarily spending more funds on Medicaid. Even if the numbers say that said politician voted for or advocates for more membership, they can still curtail expenditures by weaker benefits or benefit limits, all the while still claiming they support stronger Medicaid. The election of this idea being that median voters, who view Medicaid as a social good, will be drawn to their side, as they too want to support such welfare programs (and do so with their votes). The levels of support shown in the model are adhered for the very reasons I outlined. Conservatives naturally do not want to expand welfare programs, regardless

of cost, hence their strict income requirements. However, when facing competition, they move to meet the liberals in the middle with expanded income requirements to include more people, but still leaving options to curtail costs available. Liberals that face uncontested elections support welfare as much as they can, leading to their on average highest income requirements; those liberals who are facing competition keep their Medicaid expansions in check so as not to scare off slightly right-leaning moderate voters, as well as being held back by the conservatives in their legislatures. In essence, Medicaid must be examined as a social political tool, not an economic one, at least when considering social democratic forces. Politicians want to give off the appearance of being in support of Medicaid without actually paying for it in order to maintain their budgetary political tools. As Holahan noted, Medicaid programs are only expanded as far as politicians are willing to pay for them (Holahan 2007, 669).

With this new conception of the Medicaid tool in mind, a few of the outliers' digression from the framework can be understood, actually adding strength to the model. Texas has an income requirement of 25% of FPL, significantly less than the 71.47% of its conservative high competition category. But Texas also has a large Latino population, much of it falling in what could be deemed the "lower class," the segment of society Medicaid was designed to serve. If Texas had less strict income requirements, this societal group would rush to enroll, driving up Medicaid expenditures at a rate the legislature could not control or afford without other actions. Latinos, as a group, tend to be firmly left-leaning anyways, meaning that the group Medicaid expansion would benefit is not the target group of voters politicians are even trying to win over. Hence, Texan politicians, despite the competitiveness of their elections, have chosen to keep income requirements low to maintain the other political tools a rapidly growing Medicaid program would destroy. Louisiana, one of the poorest states in the US, faces a similar dilemma; with its 24% rate it is the lowest outlier in the liberal competitive category. The only difference is its lower class is large in itself, with no one social group dominating. If they too were to expand Medicaid it would quickly grow out of control, eliminating the other tools Louisianan politicians would rather rely on; satisfying the demands of liberal policy-seekers with Medicaid expansion would do little to assure reelection.

The electorate of Ohio contains, amongst others, a distinct class: the rural poor. Its income requirement rate of 96% is highest in its category, even higher than the average of the competitive conservative state category. The motivation behind such inclusiveness could be that

those who stand to benefit from Medicaid are part of the conservative base. Rural voters tend to vote conservative, but after the collapse of the steel industry and weakening of the coal industry, the backbones of many rural economies, many voters fell into the lower class. By lowering income requirements, conservative politicians insure these voters are included and remain loyal to the conservative politicians who represent them. In essence, the legislature is willing to risk budgetary issues by expanding Medicaid in order to maintain the solidarity of their political base; if liberals proposed assisting these voters via Medicaid expansions and conservatives failed to act, Ohio could become a competitive state, a situation conservatives want to avoid at all costs. Therefore, Ohio establishes fairly weak income requirements with the purpose of helping conservative constituents and shoring up the source of their electoral dominance in the process.

By viewing these outliers in a more dynamic context, it becomes clearer as to why they seem to defy the model. It would appear other states that do follow the model do not have as strong outside factors that influence their decision-making and push them outside the bounds of their respective categories. Explanation or not however, the model still sheds light on the Medicaid puzzle. Electoral competitiveness and ideology dominance influence the strength of Medicaid in the form of income requirements. Expenditures seem immune from such influence due to the unwillingness of politicians to spend more on Medicaid and risk the loss of other, more budgetary, political tools.

I now return to the original example I outlined in the Medicaid puzzle, that is the disparity between Maine and New Hampshire. In short, Maine outspent New Hampshire by $1 billion, despite their both being similarly populated New England states. In application of the framework, the forces behind this difference in program strength receive some clarity. New Hampshire falls in the conservative low competition category while Maine is a liberal high competition state. Therefore, the differences in program strength revolve around that New Hampshire politicians have no incentive for Medicaid expansion, but Maine politicians have high incentive; their reelection chances are more threatened. In terms of numbers, New Hampshire has a 47% income requirement compared to Maine's 200% requirement (Kaiser Foundation, "Adult Income"). The puzzle here is partially solved. Maine's program is stronger partially due to the factors outlined in the framework, competition and ideology. The spending difference develops due to such a stark difference in the amount of people eligible for each program; at 200% Maine has sacrificed some of its politicians' budgetary political tools.

IX. Conclusion

Despite the wealth of research available on social welfare in the US, research on Medicaid has been limited and focused on a few different explanations, primarily economic perspectives. The overall consensus has been the wealth of a state dictates the strength of its Medicaid program. This essay attempted to expand our understanding of Medicaid through the proposal of a new framework drawing from a broader social democratic perspective on social welfare via both qualitative and quantitative data about each states level of political liberalism and electoral competition. The proposed framework reveals that these factors can influence the scope of a Medicaid program, but only sheds some light on the variances in spending itself; it challenges that wealth is the only true factor.

The research done here provides evidence for a conclusion many political idealists would deem startling and disheartening: Medicaid is a political tool, nothing more. Despite the attempts of many to classify Medicaid as welfare medicine for the poor, it falls well short of this goal. Politicians see the institution as a path to election victory, not as a duty of the government. Both the functionalist and social democratic theories, taken at their core values, do not explain the use of Medicaid, as one would tend to believe. Medicaid did not arise out of the sudden US wealth nor is it a victory of labor and the left over conservative forces. Its inception may be explained by such theories, but that is a topic for another essay. The program in its current functioning fails to approach either of these ideas. As demonstrated, aspects of social democratic theory influence Medicaid, but not as a societal-political victory as the theory commonly suggests; there is no competition between liberal and conservative societal groups, only competition between liberal and conservative *politicians* seeking election. The goal of Medicaid is votes, not a better, healthier, stronger nation and society.

Given this rather sad state of affairs (depending on one's perspective), the advent of President Barack Obama's Affordable Care Act that will force states to make millions of citizens Medicaid eligible spells an uncertain fate for the program. Will it remain a political tool or will its borderline unmanageable size make it no longer useful to politicians? Will Medicaid *contraction* become the new political tool in order to serve budgetary problems? Only time will tell what path Medicaid will take. The work done here could open future forays into Medicaid analysis to more social democratic understandings instead of the economic focus that has been the norm, adding nuance to our understanding of this complex and increasingly important

component of US social welfare policy as we move forward into the implementation of broad health care reform. However, for the time being, politicians have seemed to relegate the institution to politicking and a source of votes. It would seem Representative Mills was correct in his assessment of the original legislation; the program was hastily put together, subjecting Medicaid to the politics and weaknesses we must bear today.

Works Cited

Barilleaux, Charles, Thomas Holbrook and Laura Langer. "Electoral Competition, Legislative Balance, and American State Welfare Policy." American Journal of Political Science 46.2 (2002): 415-427.

Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. "Measuring Citizen and Government Ideology in the American States, 1960-93." *American Journal of Political Science* 42.1 (1998): 327-48. *JSTOR*. Midwest Political Science Association, 25 July 2008. Web. 6 Apr. 2013. <http://www.jstor.org/stable/2991759>.

Buchanan, Robert J, Joesph C Cappelleri and Robert L Ohsfeldt. "The Social Environment and Medicaid Expenditures: Factors Influencing the Level of State Medicaid Spending." Public Administration Review 51.1 (1991): 67-73.

Coughlin, Teresa A, Leighton Ku and John Holahan. Medicaid since 1980: Costs, Coverage, and the Shifting Alliance between the Federal Government and the States. Washington DC: Urban Institute Press, 1994.

Cromwell, Jerry, Sylvia Hurdle and Gerard Wedig. "Impacts of Economic and Programmatic Changes on Medicaid Enrollment." The Review of Economics and Statistics 68.2 (1986): 232-240.

Fording, Richard C. "Government Ideology." *Stateminder*. Georgetown University, 20 Nov. 2012. Web. 5 Apr. 2013. http://stateminder.org/variables/government-ideology.

Gilmer, Todd P and Richard G Kronick. "Differences In The Volume Of Services And In Prices Drive Big Variations In Medicaid." Health Affairs 30.7 (2011): 1316-1324.

Hacker, Jacob S. The Divided Welfare State. New York: Cambridge University Press, 2002.

Henry J. Kaiser Family Foundation. Total Medicaid Spending, FY2010. 2013. 21 March 2013. http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4.

Henry J. Kaiser Family Foundation. Average Annual Growth in Medicaid Spending, FY1990 – FY2010. 2013. 21 March 2013. http://www.statehealthfacts.org/comparetable.jsp?ind=181&cat=4.

Henry J. Kaiser Family Foundation. Total Medicaid Enrollment, FY2009. 2013. 21 March 2013. http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4.

Henry J. Kaiser Family Foundation. Medicaid Enrollment as a Percent of Total Population, 2009. 2013. 21 March 2013. http://www.statehealthfacts.org/comparemaptable.jsp?ind=199&cat=4.

Henry J. Kaiser Family Foundation. Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL), January 2013. 2013. 21 March 21 2013. http://www.statehealthfacts.org/comparereport.jsp?rep=130&cat=4

Hershey, Marjorie Randon. Party Politics in America. Pearson Education Inc., 2013.

Holahan, John. "State Variation In Medicaid Spending: Hard To Justify." Health Affairs 26.6 (2007): 667-669.
Lee, Junghee and William Donlan "Health Care for the Poor: Politics, Culture, and Community." Journal of Poverty 13:2 (2009) 196-213.
Linquist, Stefanie A. "Ranney Index." *Stateminder*. Georgetown University, 25 June 2012. Web. 5 Apr. 2013. http://stateminder.org/variables/ranney-index.
Miller, Edward Alan. "State Health Policy Making Determinants, theoy, and methods: A Synthesis." Social Science and Medicine 61 (2005): 2639-2657.
Olson, Laura Katz. The Politics of Medicaid. Chichester: Columbia University Press, 2010.
Schneider, Saundra K. "Intergovernmental Influences on Medicaid Program Expenditures." Public Administration Review 48.4 (1988): 756-763.
Snyder, Laura, et al. "Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending." Issue Paper. The Henry J. Kaiser Family Foundation, 2012.
Stevens, Robert and Rosemary Stevens. Welfare Medicine in America: A Case Study of Medicaid. New York: Macmillan Publishing Company, 1974.
Van Kersbergen, Kees and Philip Manow. "The Welfare State." Caramani, Danièle. Comparative Politics. New York: Oxford University Press, 2008. 445-472.
Van Kersbergen, Kees and Uwe Becker. "Comparative Politics and the Welfare State." Keman, Hans. Comparative Democratic Politics: A Guide to Contemporary Theory and Research. New York: Sage Publications, 2002. 185-212.

Appendix 1

Independent Variables: State Legislature Ideology 1990-2010 and AVG, Ranney Index, and Resulting Category Assignments

Abbrev.	State	1990	1995	2000	2005	2010	Average	Ranney Index	Category*
AL	Alabama	60.69	54.78	53.15	39.17	41.92	49.942	0.68	C-LC
AK	Alaska	44.28	46.73	67.48	45.86	45.58	49.986	0.34	C-LC
AZ	Arizona	67.2	65.45	47.41	46.69	62.51	57.852	0.35	L-HC
AR	Arkansas	49.57	23.64	26.81	49.32	47.79	39.426	0.66	C-LC
CA	California	50.58	41.53	71.89	49.45	48.87	52.464	0.68	L-LC
CO	Colorado	44.73	49.17	25.35	37.88	65.34	44.494	0.42	C-HC
CT	Connecticut	68.26	49.39	53.05	55.09	54.82	56.122	0.57	L-HC
DE	Delaware	N/A	N/A	N/A	N/A	N/A	N/A	0.55	N/A-HC
FL	Florida	47.28	58.58	30.4	30.06	29.93	39.25	0.3	C-LC
GA	Georgia	59.41	69.46	69.32	27.95	24.89	50.206	0.6	C-HC
HI	Hawaii	71.1	72.79	72.79	57.39	58.76	66.566	0.74	L-LC
ID	Idaho	46.92	34.99	40.08	66.29	67.94	51.244	0.17	C-LC
IL	Illinois	53.05	46.09	52.29	29.36	32.83	42.724	0.52	C-HC
IN	Indiana	53.37	42.61	53.24	57.84	65.52	54.516	0.51	C-HC
IA	Iowa	40.4	25.84	26.76	27.56	28.05	29.722	0.44	C-HC
KS	Kansas	38.93	34.38	28.84	46.07	46.12	38.868	0.28	C-LC
KY	Kentucky	63.72	61.75	50.84	38.6	56.68	54.318	0.63	L-HC
LA	Louisiana	56.82	60.83	46.52	63.94	43.98	54.418	0.58	L-HC
ME	Maine	71.62	57.48	59.79	58.84	74.05	64.356	0.54	L-HC
MD	Maryland	65.86	70.66	70.66	50.14	70.66	65.596	0.7	L-LC
MA	Massachusetts	57.66	55.05	61.06	64.83	66.07	60.934	0.69	L-LC
MI	Michigan	66.22	34.71	33.37	56.21	61.29	50.36	0.39	C-HC
MN	Minnesota	68.5	46.21	52.47	41.01	49.62	51.562	0.45	L-HC
MS	Mississippi	51.06	62.12	62.56	30.86	32.02	47.724	0.72	C-LC
MO	Missouri	54.66	44.91	61.8	47.09	44.3	50.552	0.53	C-HC
MT	Montana	40.03	33.45	31.98	57.11	56.24	43.762	0.31	C-LC
NE	Nebraska	25	27.06	47.76	46.03	32.73	35.716	0.62	C-HC
NV	Nevada	44.07	57	65.79	63.34	41.41	54.322	0.35	L-HC
NH	New Hampshire	63.88	36.91	36.87	58.8	55.94	50.48	0.34	L-HC
NJ	New Jersey	52.25	52.38	52.04	67.74	64.05	57.692	0.42	L-HC
NM	New Mexico	66.18	47.58	46.3	46.67	69.57	55.26	0.36	L-HC
NY	New York	63.08	42.92	43.39	44.28	67.74	52.282	0.48	L-HC
NC	North Carolina	45.95	53.58	36.86	34.86	64.18	47.086	0.62	C-HC
ND	North Dakota	55.19	51.8	37.21	40.29	45.89	46.076	0.44	C-HC
OH	Ohio	59.56	34.11	33.43	33.37	53.05	42.704	0.29	C-LC

OK	Oklahoma	42.36	40.48	41.61	48.68	46.62	43.95	0.57	C-HC
OR	Oregon	65.94	55.48	55.09	63.15	66.91	61.314	0.46	L-HC
PA	Pennsylvania	59.59	40.49	36.08	53.32	55.3	48.956	0.36	C-HC
RI	Rhode Island	60.22	60.7	59.91	61.52	61.27	60.724	0.7	L-LC
SC	South Carolina	47.81	39.44	55.76	26.58	25.99	39.116	0.44	C-HC
SD	South Dakota	41.15	41.86	33.72	33.72	34.56	37.002	0.25	C-LC
TN	Tennessee	63.88	45.4	44.37	55.1	56.74	53.098	0.58	L-HC
TX	Texas	43.42	42.1	34.68	26.44	28.62	35.052	0.38	C-HC
UT	Utah	27.53	31.53	29.99	29.18	29.18	29.482	0.25	C-LC
VT	Vermont	59.9	45.24	37.23	49.7	56.43	49.7	0.59	C-HC
VA	Virginia	67.6	68.35	72	70.06	65.47	68.696	0.39	L-HC
WA	Washington	68.41	59.19	62.61	64.59	68.59	64.678	0.56	L-HC
WV	West Virginia	49.56	35.96	33.7	49.64	60.86	45.944	0.69	C-LC
WI	Wisconsin	66.59	66.57	51.72	66.67	66.67	63.644	0.42	L-HC
WY	Wyoming	48.18	30	26.77	48.26	48.23	40.288	0.28	C-LC

***Category Legend**
C-LC --> Conservative controlled low competition
C-HC --> Conservative controlled high competition
L-LC --> Liberal controlled low competition
L-HC --> Liberal controlled high competition

Appendix 2

Dependent Variables: Medicaid Expenditure Growth Rate and AVG, FPL % Income Requirement

State	1990-2001	2001-2004	2004-2007	2007-2010	Average Rate	FPL % Income Requirement
Alabama	0.1238	0.0809	0.0397	0.049	7.33%	23%
Alaska	0.129	0.1524	0.0234	0.082	9.67%	78%
Arizona	0.1537	0.2277	0.1026	0.123	15.17%	106%
Arkansas	0.1116	0.1066	0.0491	0.084	8.78%	16%
California	0.1062	0.0851	0.0506	0.054	7.40%	106%
Colorado	0.1339	0.0695	0.0359	0.114	8.83%	106%
Connecticut	0.0941	0.0625	0.0289	0.097	7.06%	191%
Delaware	0.1513	0.1018	0.0768	0.092	10.55%	120%
Florida	0.1184	0.141	0.0175	0.086	9.07%	56%
Georgia	0.1149	0.212	-0.0874	0.036	6.89%	48%
Hawaii	0.1088	0.1252	0.0622	0.092	9.71%	133%
Idaho	0.1462	0.1085	0.0462	0.08	9.52%	37%

Illinois	0.1113	0.0866	0.0765	0.066	8.51%	139%
Indiana	0.0958	0.0658	0.0132	0.05	5.62%	24%
Iowa	0.0921	0.1037	0.0367	0.071	7.59%	80%
Kansas	0.119	0.0184	0.0605	0.045	6.07%	31%
Kentucky	0.116	0.0835	0.0214	0.069	7.25%	57%
Louisiana	0.1075	0.0597	0.0161	0.09	6.83%	24%
Maine	0.1078	0.1477	-0.0081	0.049	7.41%	133%
Maryland	0.0989	0.1234	0.0478	0.092	9.05%	122%
Massachusetts	0.0723	0.0851	0.0493	0.046	6.32%	133%
Michigan	0.0971	0.0448	0.0387	0.079	6.49%	64%
Minnesota	0.0926	0.1305	0.0319	0.07	8.13%	215%
Mississippi	0.1347	0.1103	-0.0138	0.08	7.78%	29%
Missouri	0.1586	0.0895	0.0213	0.072	8.54%	35%
Montana	0.088	0.1125	0.0288	0.085	7.86%	54%
Nebraska	0.129	0.0636	0.0174	0.04	6.25%	58%
Nevada	0.1473	0.1525	0.0616	0.066	10.68%	84%
New Hampshire	0.1319	0.0958	0.0006	0.046	6.86%	47%
New Jersey	0.1055	0.0379	0.0369	0.047	5.68%	200%
New Mexico	0.1573	0.1475	0.0588	0.093	11.41%	85%
New York	0.0919	0.0911	0.0212	0.055	6.48%	150%
North Carolina	0.1397	0.098	0.0553	0.035	8.20%	47%
North Dakota	0.0675	0.0623	0.0117	0.106	6.19%	57%
Ohio	0.0915	0.1105	0.0373	0.053	7.31%	96%
Oklahoma	0.1018	0.0723	0.0918	0.069	8.37%	51%
Oregon	0.1575	-0.0065	0.0326	0.114	7.44%	39%
Pennsylvania	0.1241	0.0892	0.0392	0.056	7.71%	58%
Rhode Island	0.0939	0.1159	0.0130	0.037	6.50%	181%
South Carolina	0.1238	0.0877	0.0150	0.075	7.54%	89%
South Dakota	0.0968	0.0648	0.0289	0.082	6.81%	50%
Tennessee	0.1298	0.0862	0.0032	0.061	7.00%	122%
Texas	0.1291	0.1159	0.0811	0.097	10.58%	25%
Utah	0.1071	0.1401	0.0357	0.073	8.90%	42%
Vermont	0.1326	0.0988	0.0409	0.114	9.66%	191%
Virginia	0.1048	0.0829	0.0800	0.092	8.99%	30%
Washington	0.1229	0.0669	0.0278	0.068	7.14%	71%
West Virginia	0.1293	0.0774	0.0365	0.055	7.45%	31%
Wisconsin	0.0954	0.0357	0.0324	0.097	6.51%	200%